VHA Performance Measurement In Cardiac Care

A Map for VHA Cardiac Performance Measurement in FY 2005 and beyond…

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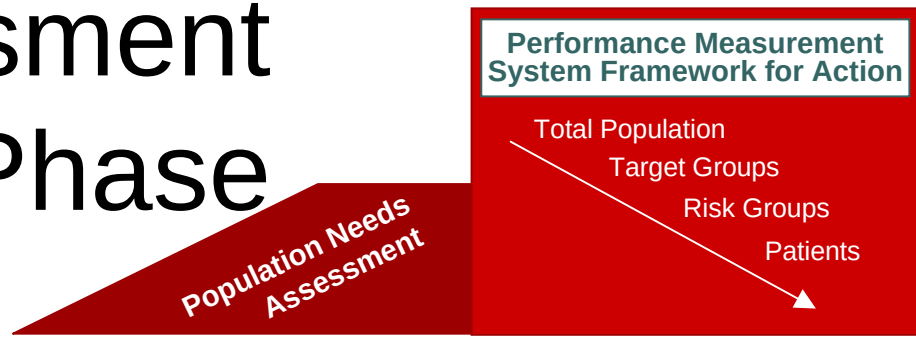
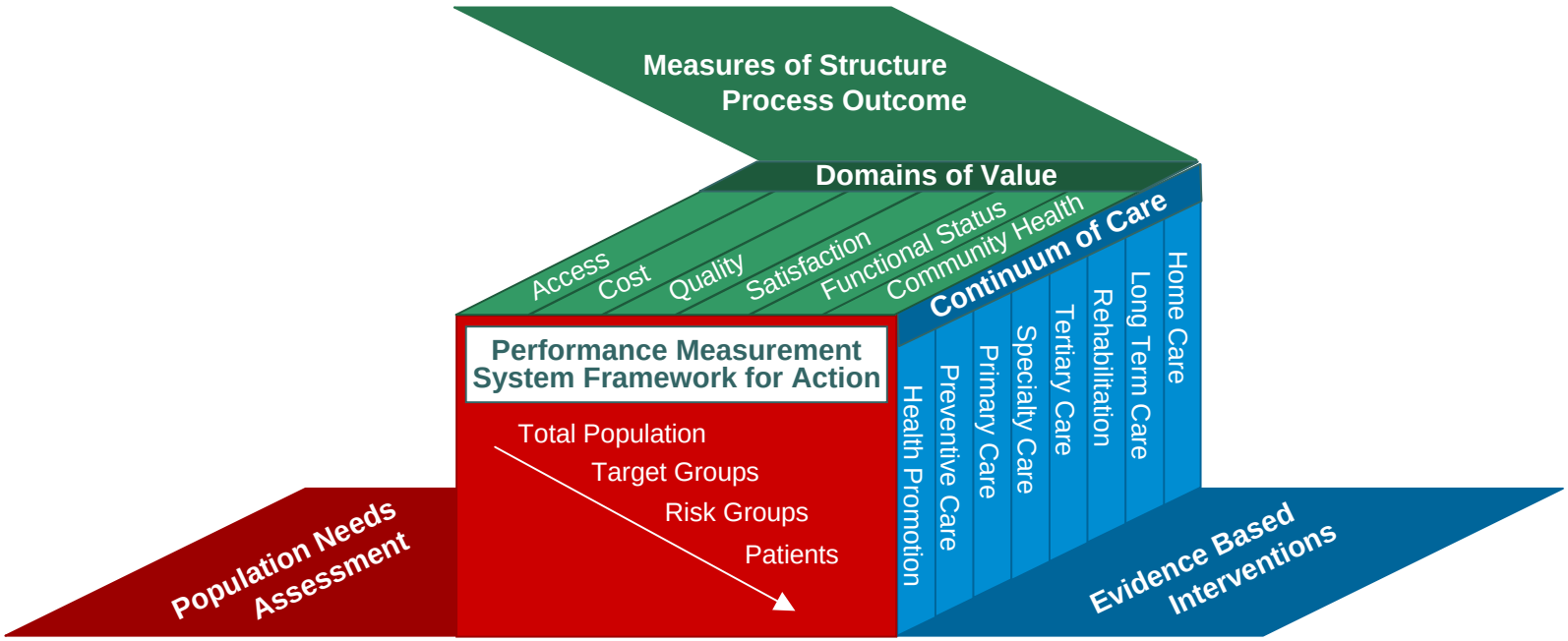
Needs Assessment Prioritization Phase



- Inventory the health of and risk inherent in the population served
- Gain insight into disease and trajectory of illness for critical populations
- Estimate the burden of illness (patient and health care system)
- Gap Analysis of requirements
  - New or improved service is needed
  - Outcomes less than optimal
  - Update to existing practice, process or service
  - New skills, capacity, capabilities or infrastructure
- Target an ‘at-risk population’

Performance Measurement System Framework for Action

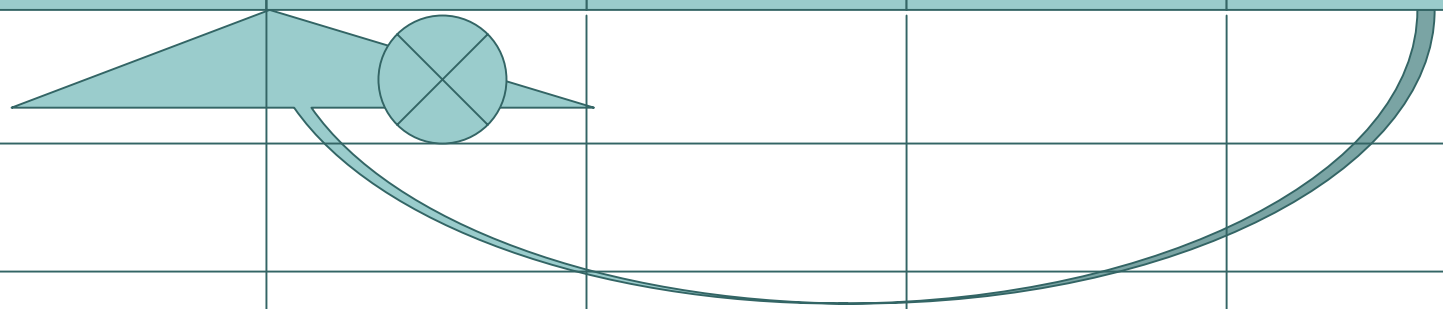


Continuum of Cardiovascular Disease HTN

Days

7 30 60 360

Clinical Strategy	*Primary Prevention*	*Secondary Prevention*	*Initial Presentation*	*Discharge*	*Follow-up*
Assessment Risk					
Evaluation Testing					
Therapy					
Education Counseling					
Clinical Events					



Recommendations to Improve BP Control and Management

Providers

- Greater use of thiazide-type diuretics
- Greater use of fixed-dose combinations
- Need for at least 2-3 AHT drugs in majority of HT patients
- Rational combining of AHT medications, as per various guidelines

Systems

- Proper BP Measurement
- Recording of BP in CPRS VS package
- Use of hypertension clinical reminders
- Feedback to providers, VAMCs, and VISNs on BP control and AHT medication usage
- Use of home BP manometers to improve adherence

Patients

- To know their BP numbers
- To know their BP goals
- In lifestyle recommendations to prevent or treat hypertension
- That most patients need at least 2-3 drugs to control BP
- On proper BP measurement

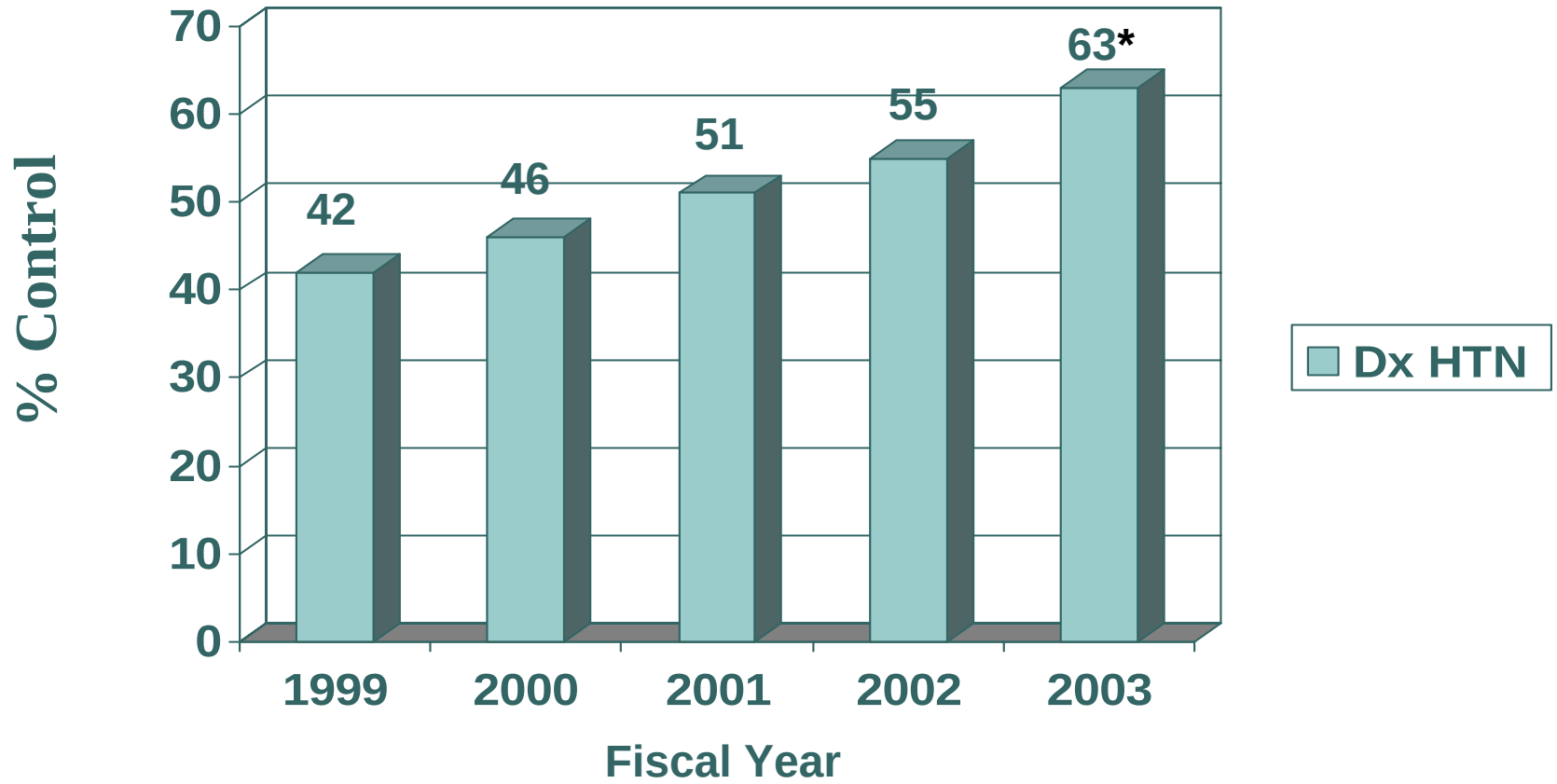
BP Control and Management in VHA

- Optimize secondary prevention strategies in the management of HTN
- Series by Name –

For patients with an active diagnosis of HTN:

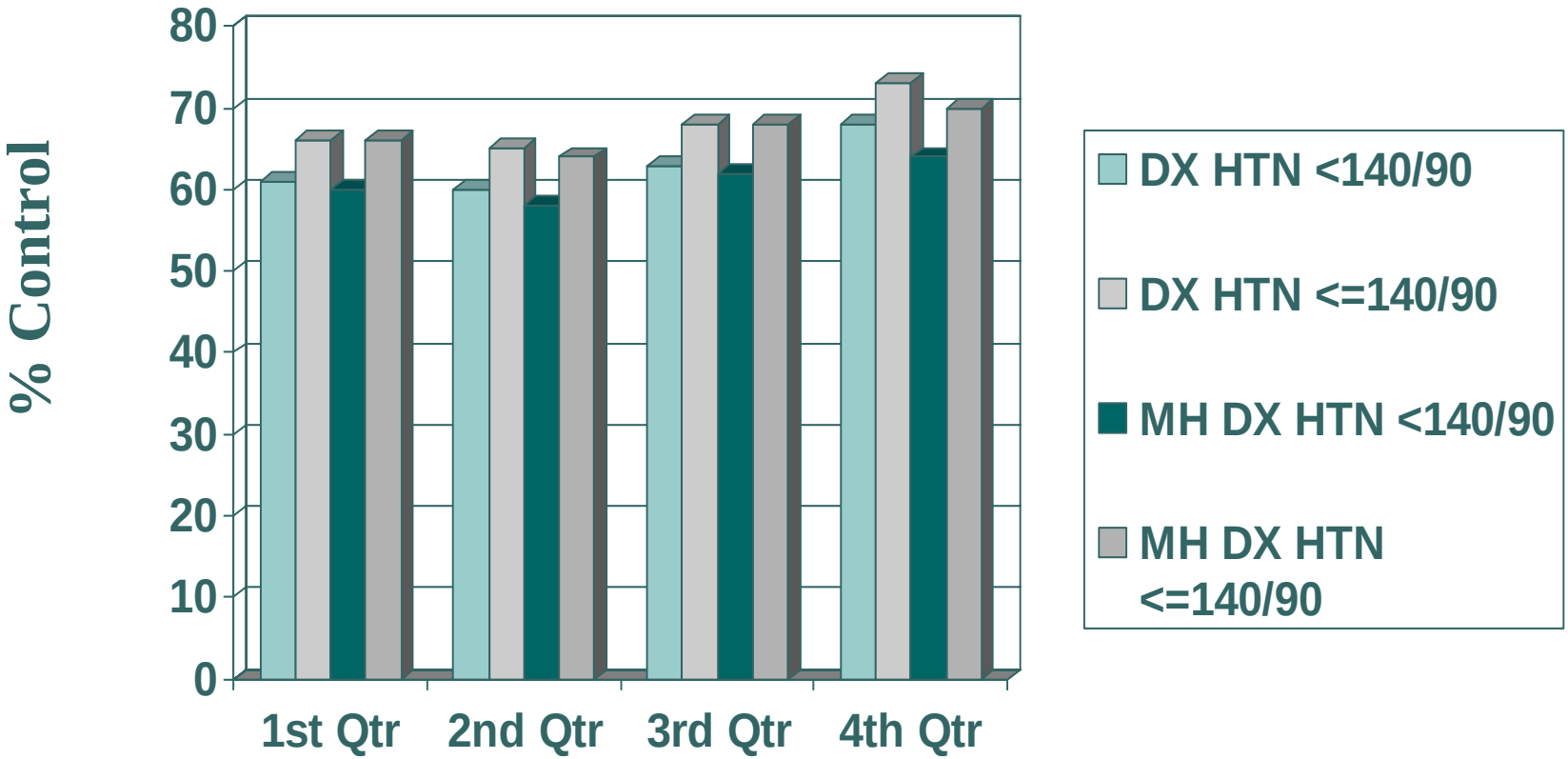
- Percent of patients with BP < or = 140/90 (PM)
- Percent of patients with BP > or = 160/100 or not recorded (PM)

Patients with Diagnosis of HTN BP Control rates < 140/90

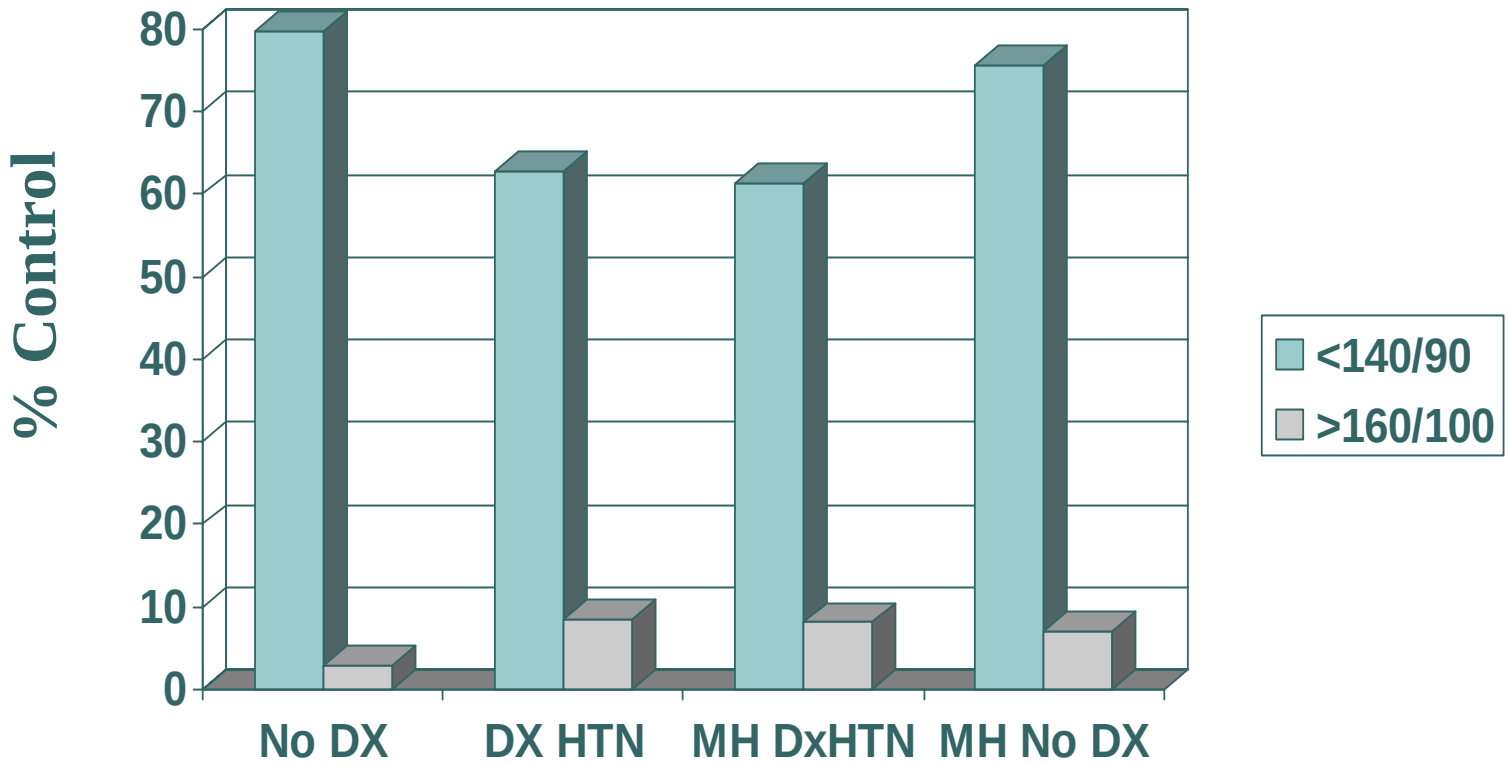


•*Note*5% higher in 2003 when ≤ 140/90 mm Hg used as criterion (to be comparable to HEDIS)*

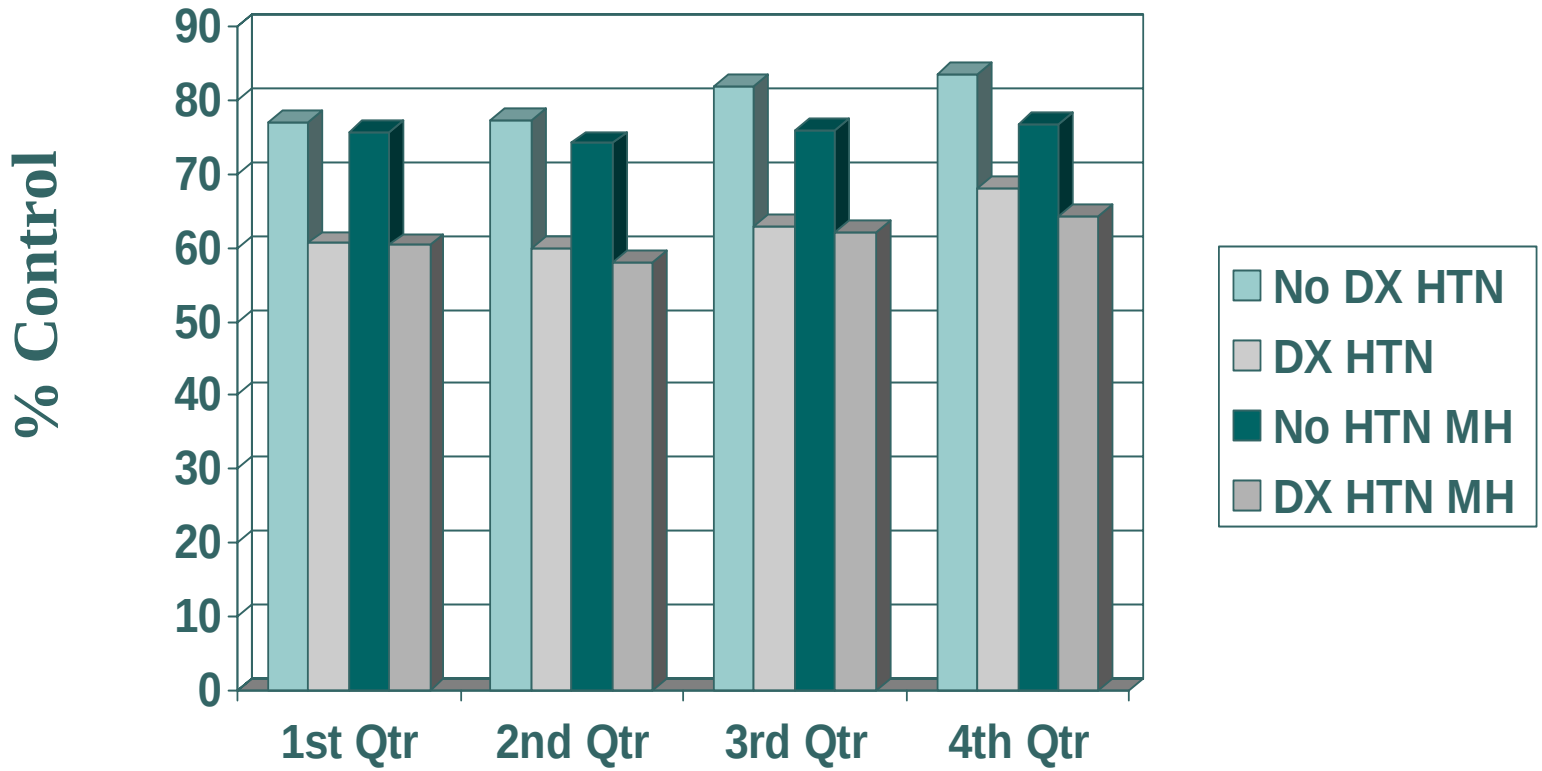
FY 2003 All Cases Sampled Percent BP < 140/90 VS Percent BP ≤140/90



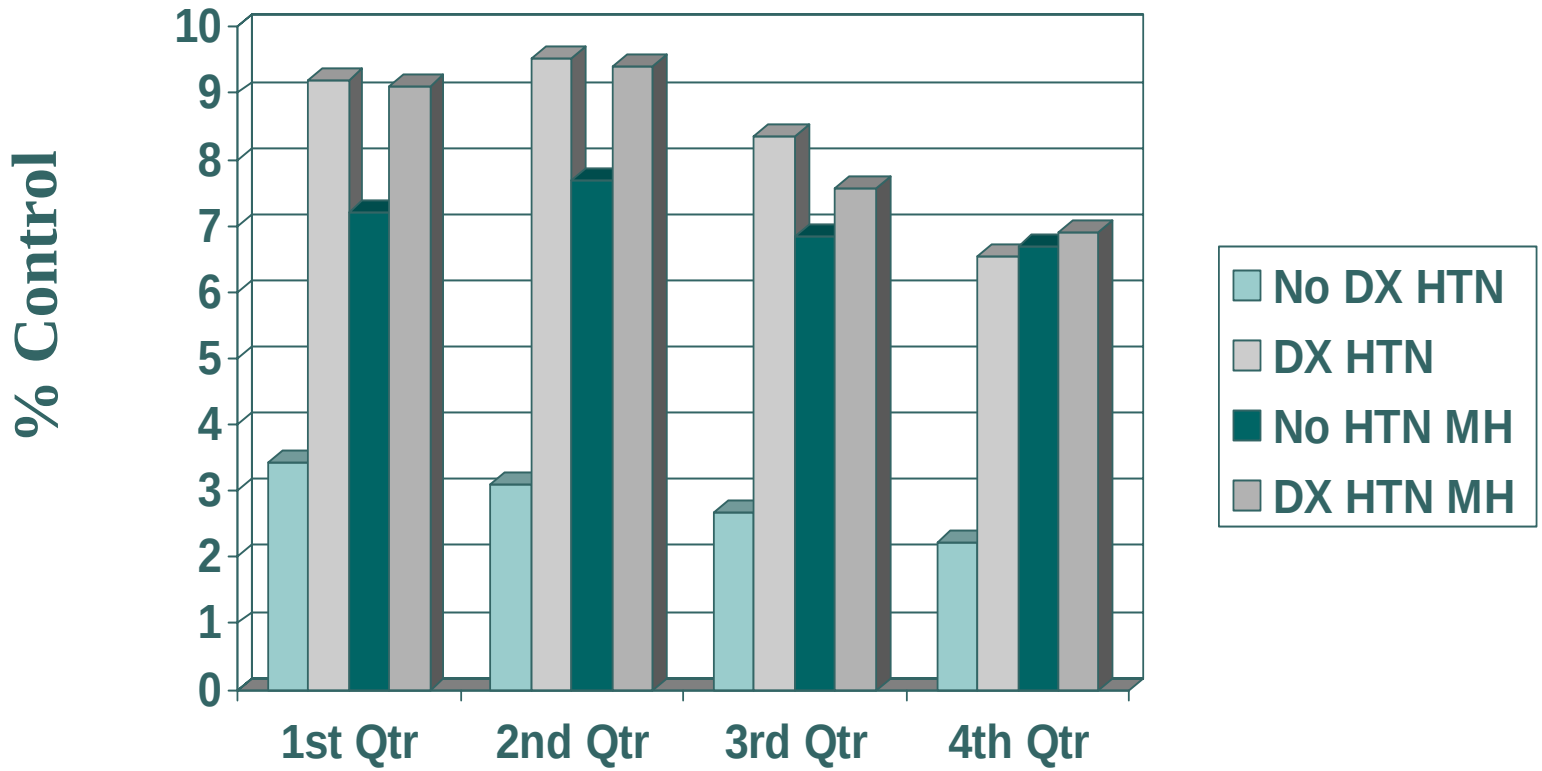
All Cases Sampled in 2003 Blood Pressure Control in Four Cohorts



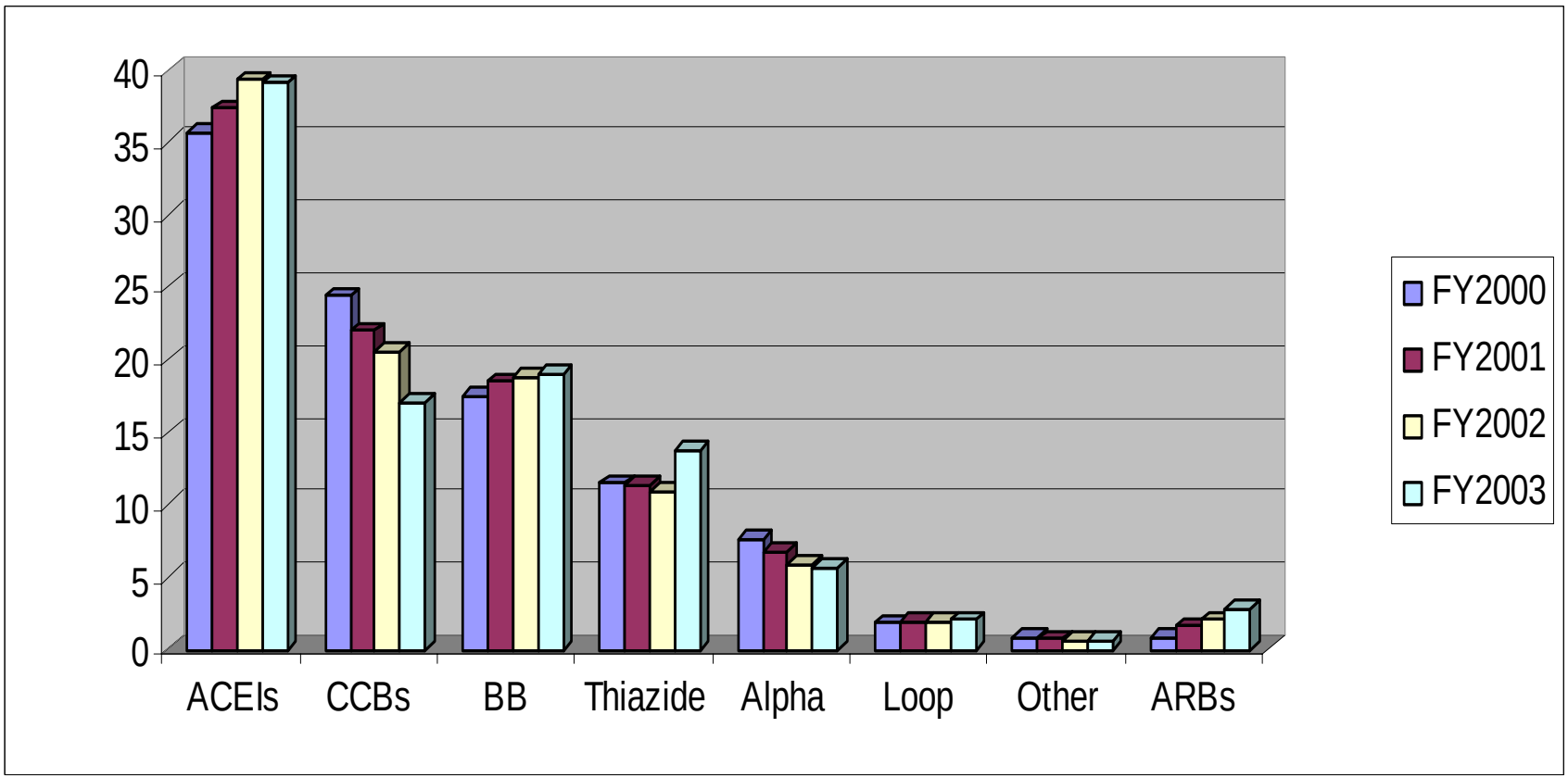
FY 2003 All Cases Sampled by Quarter
Percent BP < 140/90



FY 2003 All Cases Sampled Percent BP > 160/100



Antihypertensive Medications Patients on Monotherapy



Continuum of Cardiovascular Disease - HF

	Primary Prevention	Secondary Prevention	Initial Presentation	Discharge	Follow-up
					Days
					7 30 60 360
Assessment Risk				⊗	
Evaluation Testing					
Therapy		⊗		⊗	
Education Counseling		⊗		⊗	
Clinical Events					

Secondary Prevention in Heart Failure – Antecedent Care

- Optimize the Outpatient Management of Heart Failure in an effort to prevent HF admissions
- Series by Name –

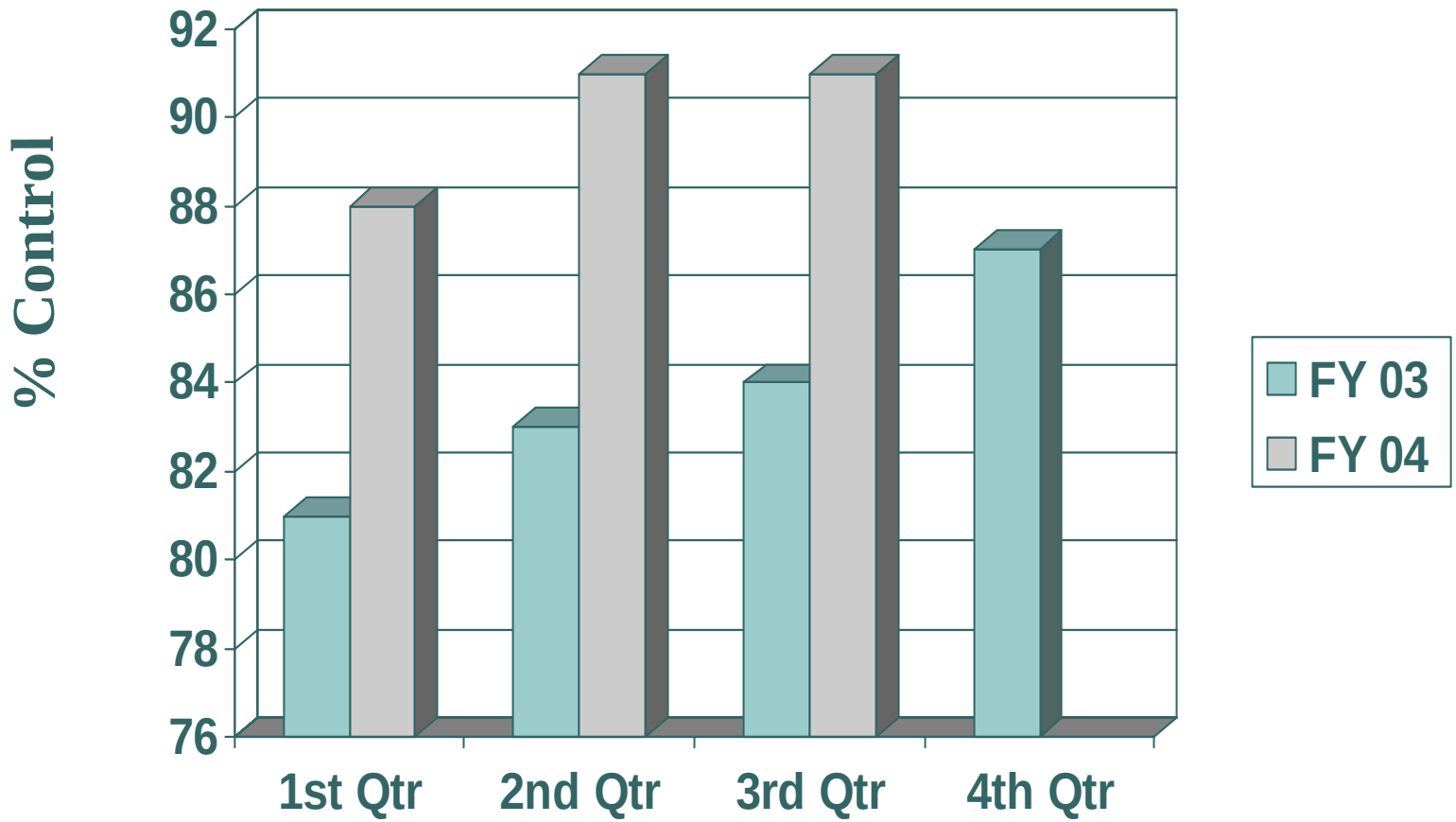
For Hospitalized HF patients:

- Percent of HF Inpatients with EF<40 on ACEI prior to admission (PM)
- Percent of HF Inpatients with weight instruction prior to admission (PM)
- Percent of HF Inpatients with discharge instructions in weight, diet, and medications (PM)

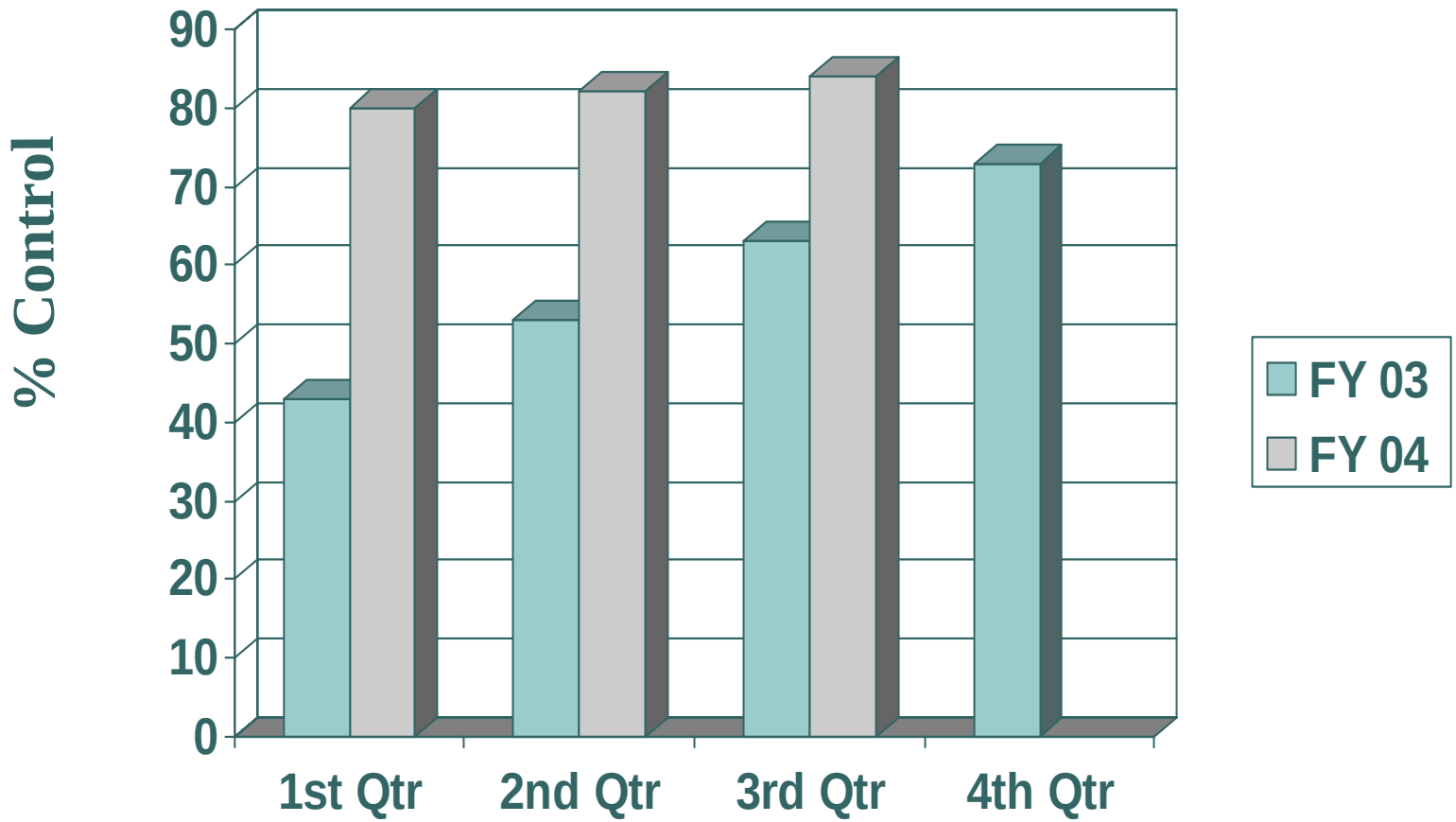
Indicator Highlights – Secondary Prevention

- Why –
  - HF as an ambulatory care sensitive condition
  - 80/20 rule HF in top 5 VHA diagnosis with high readmission rates
  - Low likelihood of treatment by multiple providers
  - Preventive strategies often under-prescribed
  - Patient education key in managing this chronic condition

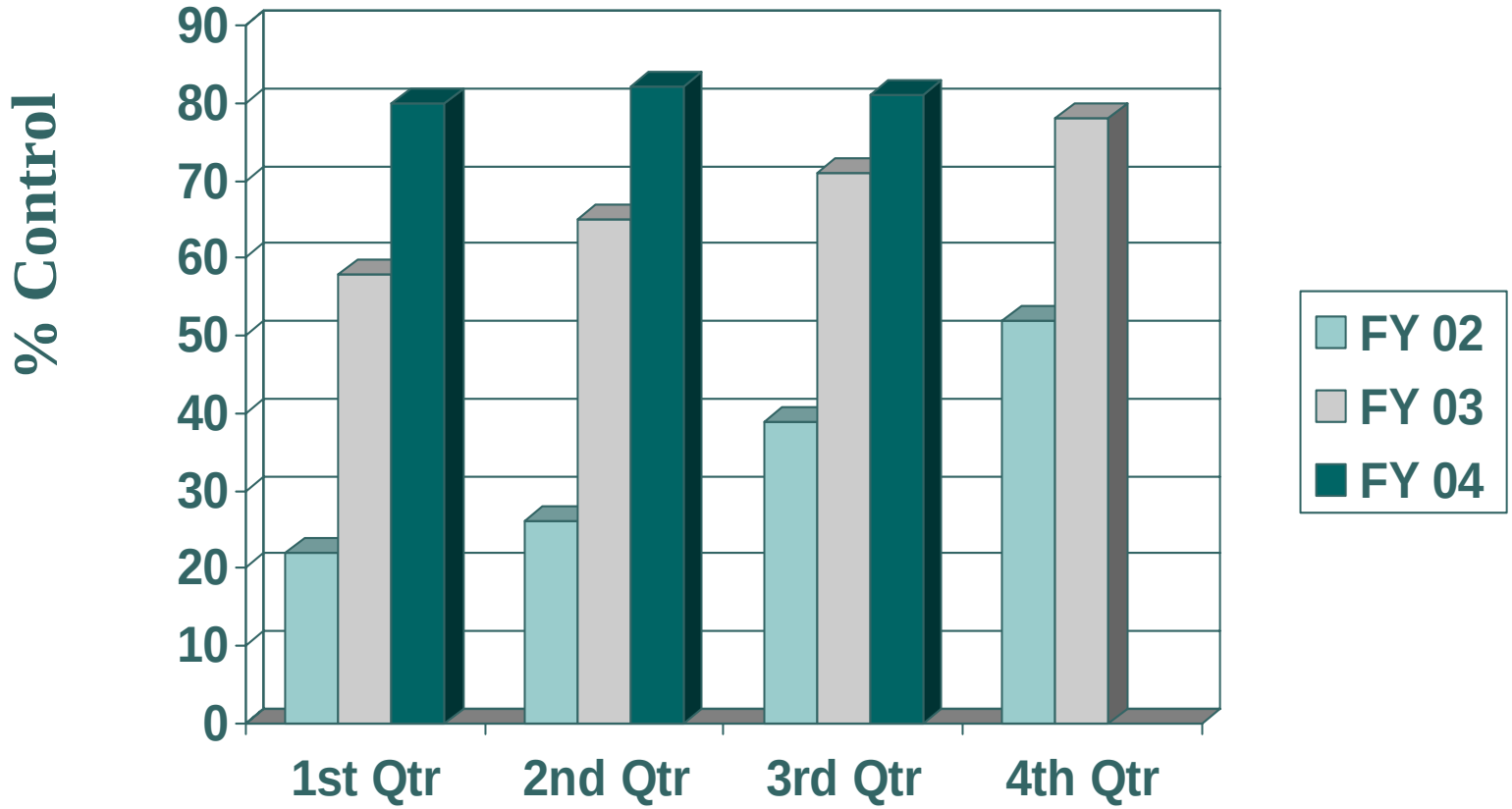
Antecedent Care – HF Inpatients with EF<40 on ACEI Prior to Admission



Antecedent Care – HF Inpatients with Weight Instruction Prior to Admission

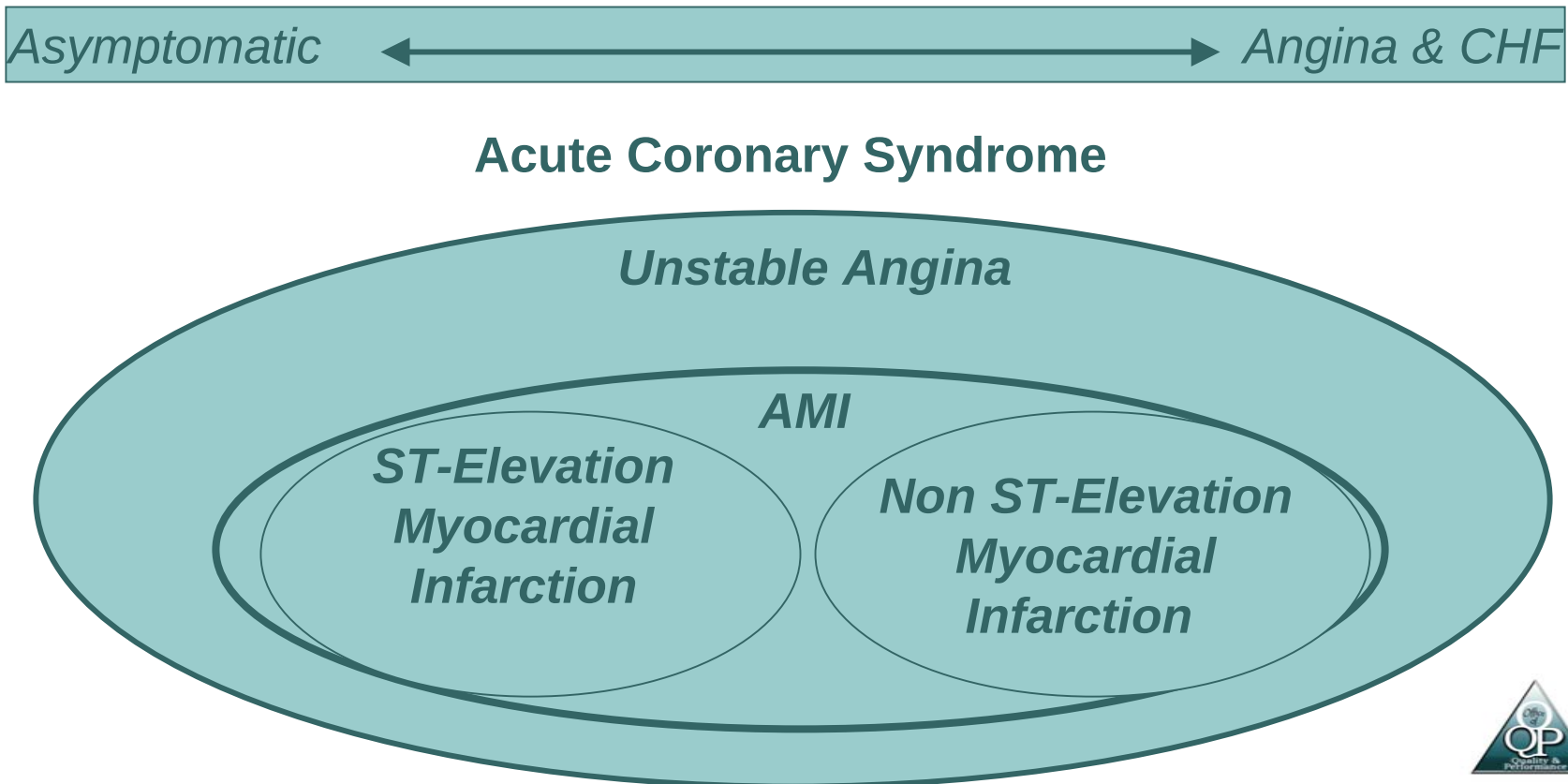


HF Inpatients with Diet, Weight, and Medication Instruction Prior to Discharge



Acute Coronary Syndrome

- Manifestations Continuum of ACS



Coronary Artery Disease

- 5-7 million seen annually with ACI
  - 50% false positive rate among ACI admissions
  - 5% ACI and 3% AMI false negative rate
  - STEMI 30%, NSTEMI 25%, UA 38%, 7% Misc.
- In VHA
  - STEMI 24%, NSTEMI 38%, UA 33%, 4% Misc.
  - Over 25,000 admission to VHA facilities

Challenges Time to Treat

- AMI, UA, from non-cardiac causes
- Survival and degree of damage depends on rapid diagnosis and appropriate treatment
- Interrupt cascade (plaque, thrombus, flow, ischemia, necrosis)

- *Given the relationship between treatment delay and death,* →
- *a determination of the likelihood of acute ischemia caused by coronary artery disease should be made in all patients with chest pain*

Acute Coronary Syndrome in VHA

First facility …	Tertiary	Non-tertiary	Non-VA Hospital	Total
STEMI seen in <12	151 (52%)	80 (28%)	56 (20%)	287 (11%)
STEMI seen in >12	132 (56%)	68 (29%)	34 (14%)	234 (9%)
NSTEMI	425 (54%)	207 (27%)	147 (19%)	779 (31%)
UA	401 (60%)	215 (32%)	47 (7%)	663 (26%)
Unable to stratify risk	277 (48%)	188 (32%)	115 (20%)	580 (23)%
Total	1386 (54%)	758 (30%)	399 (16%)	2543 (10(

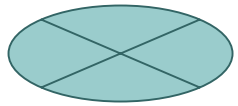
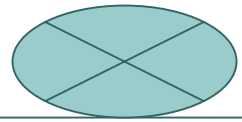
Comparing Codes to Classification

ICD9 Code	410	411	Total
STE MI	86%	14%	24%
NSTE MI	80%	20%	38%
Unstable Angina	6%	94%	33%
Missing	9%	91%	4%
Total	1365 **54%**	1178 **46%**	2543 **100%**

Continuum of Cardiovascular Disease - Acute Coronary Syndrome

Days

7 30 60 360

	Primary Prevention	Secondary Prevention	Initial Presentation	Discharge	Follow-up
Assessment Risk					
Evaluation Testing					
Therapy					
Education Counseling					
Clinical Events					

Early Continual Risk Stratification

	Initial Presentation	*Cardiac Care / 1st 24 Hours*	*Hospital Phase*	*Pre-Discharge*	*Follow-up*
GOAL:	**Identify early invasive v.s. medical candidates**	**Assess effective-ness of acute intervention and need for rescue**	**Segregate complicated from uncomp-licated infarction and UA**	**Assess stabilized patient risk and identify candidate for cath and plan for further testing**	**Execute plan for further testing, rehabilita-tion, and risk factor modifica-tion**
Physical Exam					
History					
ECG					
Biochemical Markers					
Invasive Procedures					
Noninvasive Testing and Imaging					

Assessment and Risk Stratification at Initial Presentation

- Optimize the Diagnosis and Management of ACS through stratification into appropriate treatment groups
- Series by Name –

For Hospitalized ACS patients:

- Initial Risk Stratification *variable collection*
- Timely (10 Minutes) In-hospital EKG (PM)
- Timely (60 Minutes) initial result of serial troponin measurement (PM)
- High risk and moderate-high risk - Cardiology involvement within 24 hours (PM)

Indicator Highlights – Risk

- Why –
  - Highest risk benefit most from aggressive interventions
  - Low risk care can be more selective and resource efficient
- Targeted evidence based intervention, risk reduction, and enhanced survival
- Early and continual quantification of short-term and long term risk
- Discriminatory capability of models balance between simplicity and complexity
- Drive recording of and collection of these variables

Risk Stratification

- Tools: TIMI-STEMI, GUSTO STEMI, TIMI-NSTEMI, PURSUIT-NSTEMI, PREDICT, CCP (Crusade)
- Demographics
  - Age, female, ethnicity
- Physical examination and hemodynamics
  - BP, Pulse, CHF, Shock, pulmonary edema
- Medical history and risk factors
  - DM, HTN, angina, prior MI, coronary stenosis, or stroke, preadmission medications, anginal history
- ECG
  - Infarction location, ST , number of leads
- Biochemical markers
  - Elevated troponin, CK-MB

Indicator Highlights – ECG

- Accurate identification of ischemic ST-segment
- Critical prognostic information (i.e number leads)
- Complementary to troponin in categorizing ACS
- Time is of the essence (Pre-hospital ideal)
- Accurate interpretation key (while symptomatic)
- Applicable to patients with symptoms
- Acute arrival time is used

STE MI	**NSTE MI**	**UA**
ST Elevation or BBB new or not old	New ST Deviation	No persistent ST deviation
Troponin +	OR Troponin +	Troponin -

Indicator Highlights - Troponin

- Troponin
  - Replaced CK-MB as GOLD standard;
  - TnT or I accepted
  - Serial v.s. Isolated and Point-of Care testing
  - Peak levels after 6 hours
  - False positives (most accurate in 1st time AMI)
  - Significant level (2 SD) Intermediate Coronary Syndrome
  - Time of chest pain/symptom onset critical
  - Terminal marker of necrosis
  - IMA evolving as negative predictor

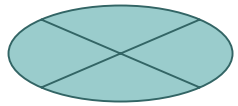
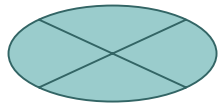
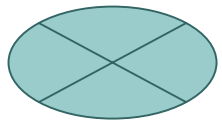
Indicator Highlights – Cardiology Involvement in 24 hours

- Cardiologist in initial 24 hours
  - May delay treatment or prompt less than optimal level of care if systematic approach not addressed
  - Local unavailability can be addressed through telemedicine, documented phone consultation
  - Cardiologist, Fellow, Resident with appropriate supervision
  - Catheterization assumes involvement

Continuum of Coronary Artery Disease

Days

7 30 60 360

	Primary Prevention	*Secondary Prevention*	*Initial Presentation*	*Discharge*	*Follow-up*
Assessment Risk					
Evaluation Testing					
Therapy					
Education Counseling					
Clinical Events					

Use and Timing of Early Invasive Treatment at Initial Presentation

- Optimize the timely use of early invasive strategies for high risk candidates
- Series by Name –

For Hospitalized ACS patients:

- Appropriate receipt of reperfusion subcategorized by thrombolysis and PCI (PM)
- Timely administration of thrombolytic therapy (PM)
- Timely receipt of primary PCI (PM)
- Mean (Median) time to thrombolytic therapy (SI)
- Mean (Median) time to PCI (SI)

Indicator Highlights- Revascularization

- High risk candidates
  - *STEMI/BBB, troponin positive, <12 hours from onset
  - NSTEMI, troponin positive
- Routine invasive v.s. selective invasive NSTEMI controversy
  - GP IIb/IIIa Receptor Blocker
  - Platelet Aggregation Inhibitors
  - LMWH
- Agents reteplase, tenetepalse, alteplase, streptokinase
- Insufficient evidence favoring stenting over PTCA
- Effect depends on timing (within 6 hours – outside 12 hours)
- *30 minutes door-to-needle thrombolytic (30 minutes-NHAAP)
- *120 minutes door-to-treatment PCI

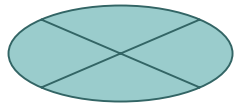
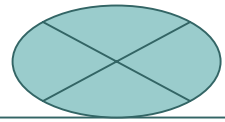
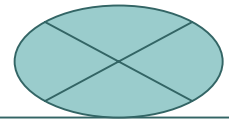
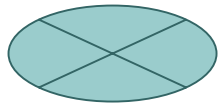
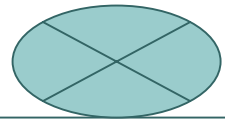
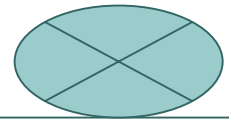
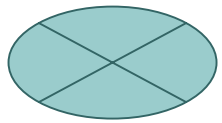
NSTEMI Early Invasive Strategy

- Recurrent Angina, in spite of medical treatment
- Elevated troponin
- New ST depression
- CHF
  - S3 gallop
  - Worsening rales
  - Chest xray evidence of pulmonary edema
  - New /worsening mitral insufficiency
- High risk fining on non-invasive stress testing
- EF<40% on non-invasive study
- Hemodynamic instability
- Sustained V tach
- Prior CABG
- PCI within previous six months

Continuum of Coronary Artery Disease

Days

7 30 60 360

	Primary Prevention	*Secondary Prevention*	*Initial Presentation*	*Discharge*	*Follow-up*
Assessment Risk					
Evaluation Testing					
Therapy					
Education Counseling					
Clinical Events					

Continual Assessment and Risk Stratification

- Optimize the diagnosis and management of ACS through stratification into appropriate treatment groups prior to and after discharge
- For ACS patients:
  - High and moderate-high risk - Diagnostic Catheterization prior to discharge (PM)
  - High and moderate-high risk – Seen by Cardiology in 60 days (PM)
  - Moderate-low risk – Plan for further work-up to include stress testing and possible catheterization prior to discharge (PM)

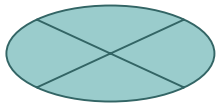
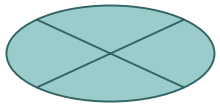
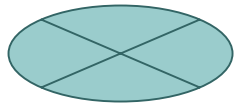
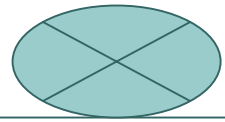
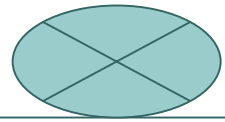
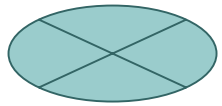
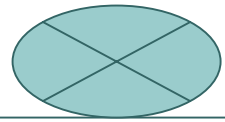
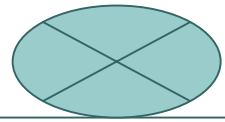
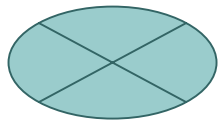
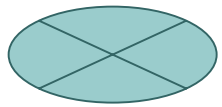
Indicator Highlights

- Who /When
  - High and moderate high risk patients must have cardiac catheterization prior to discharge
  - Moderate-low must have a plan at discharge including stress testing and angiography
  - Will accept higher level of care
- Efficient use of resources indicates visit with Cardiology in 60 days for High and Moderate-high risk
- **Bottom line: did the risk match treatment regardless of who supplied care**

Continuum of Coronary Artery Disease

Days

7 30 60 360

	Primary Prevention	*Secondary Prevention*	*Initial Presentation*	*Discharge*	*Follow-up*
Assessment Risk					
Evaluation Testing					
Therapy					
Education Counseling					
Clinical Events					

Risk Factor Modification and Secondary Prevention

- Stabilize vulnerable plaques through statin- and other agent mediated lowering of lipids
- Series by Name –

For Post hospitalized ACS patients:

- ACS post hospitalization (greater than 8 weeks) with lipids <100 (PM)
- ACS post hospitalization (greater than 8 weeks) with lipids ≥120 (PM)

Indicator Highlights

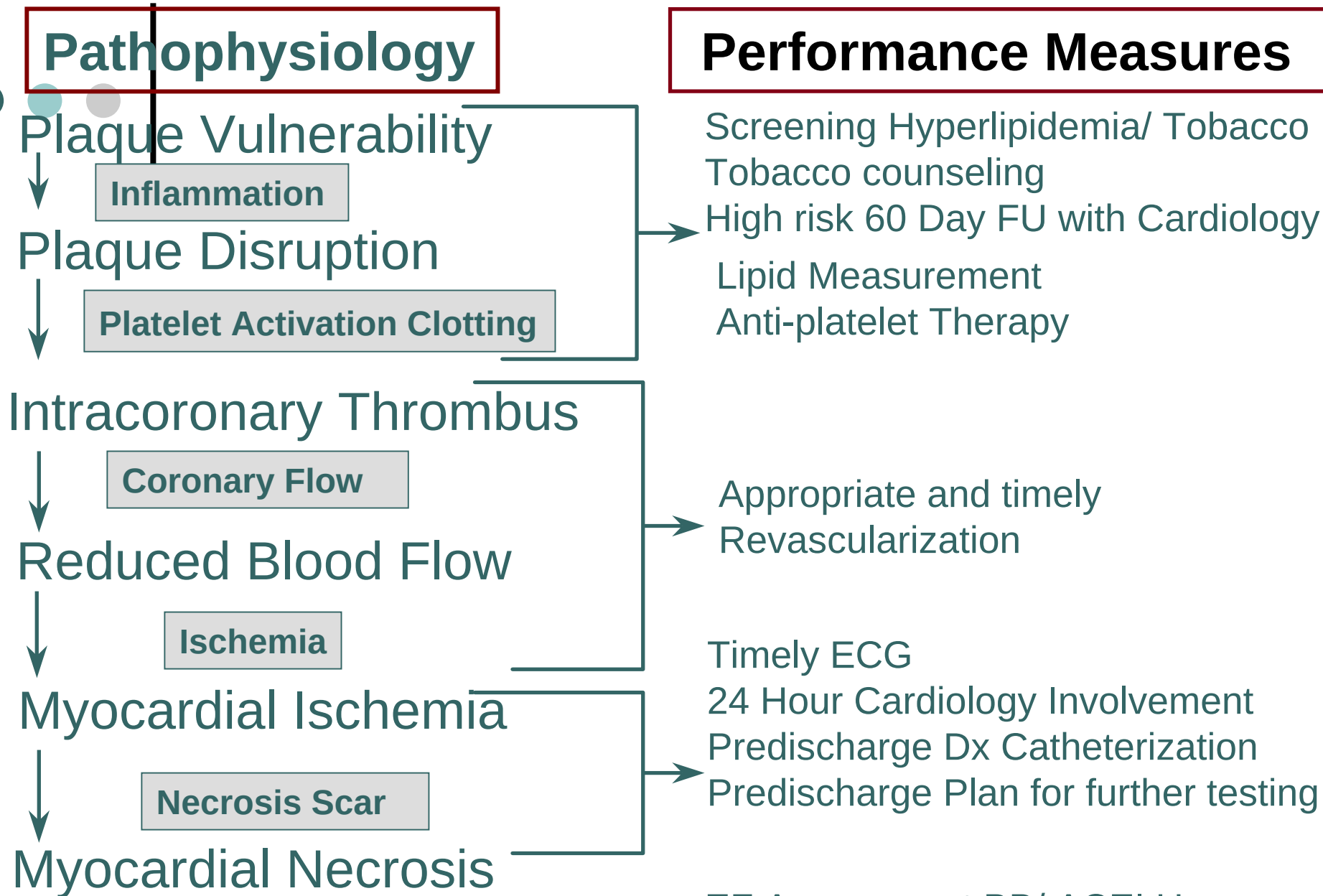
- The Lipid Panel
  - Measured within 24 hours of admission v.s. pre-discharge v.s post discharge (within 12 weeks)
  - Statins and other agents without LDL-c measurement and adjust at first visit v.s. not dependent on LDL
  - When to start - i.e. CCU
  - Controversy over correct LDL goal
    - Threshold effect
    - Absolute gain not linear (higher LDL/ higher gain)
- Agent – Statins majority of trials
- Applies to CAD equivalent patients (Diabetes and non-cardiac vascular disease)

Other Considerations

- ACC/AHA Guidelines revision
  - Medication use glycoprotein IIb/IIIa Inhibitors, LMWH, antiplatlet therapy
- Structure issues
  - Telemedicine Hub Spoke
  - Facility Characteristics
    - Cardiologist/ catheterization availability
    - Urban, rural, tertiary
    - ER Resources and skills
    - Transfers
    - High volume locations simply perform better
- Significant Endpoints
  - Mortality at 30, 90, 180, 365
  - Non fatal MI
  - Worsening Heart Failure, Cardiac arrest, Recurrent severe ischemia, Stroke

Important Notes …

- 411 added to 410 population to inpatient sample
- Expand sampling to follow this group into their outpatient continuum of care
- JCAHO Measure related to ASA, Beta Blocker, ACEI and LVEF assessment continue


Pathophysiology
Performance Measures
Plaque Vulnerability
Inflammation
Plaque Disruption
Platelet Activation Clotting
Intracoronary Thrombus
Coronary Flow
Reduced Blood Flow
Ischemia
Myocardial Ischemia
Necrosis Scar
Myocardial Necrosis
Screening Hyperlipidemia/ Tobacco
Tobacco counseling
High risk 60 Day FU with Cardiology
Lipid Measurement
Anti-platelet Therapy
Appropriate and timely
Revascularization
Timely ECG
24 Hour Cardiology Involvement
Predischarge Dx Catheterization
Predischarge Plan for further testing
EF Assessment BB/ ACEI Use
Timely Serial Troponin

Performance Reporting

...improving care for veterans

Contact us

Period: Q3 2004 VISN: National

utive Dashboard
Quadrants

st
nctional Status
ality
Cancer *
Cardiovascular *
Heart Failure
Hypertension
Ischemic Heart Disease
AMI - Inpt ECG in hospital within 10 minutes of arrival
AMI - Inpt Reperf as appropriate STEMI
AMI - Inpt Reperf PCI in 120 min STEMI
AMI - Inpt Reperf Thrombolytic Therapy in 30 min STEMI
AMI - Inpt Risk Cardiology involvement in 24 hours STEMI and troponin +
AMI - Inpt Troponin returned within 60 minutes of initial draw
AMI - Outpt LDL-c <

Access	PM	QD
Total:	8	--
Exceptional:	2	--
On Target:	--	--
At Risk:	--	
Underperforming:	6	--
VHA Best:	--	
Above Nat'l Avg:	--	

Cost	PM	QD
Total:	5	--
Exceptional:	--	--
On Target:	3	--
At Risk:	--	
Underperforming:	2	--
VHA Best:	--	
Above Nat'l Avg:	--	

Functional Status	PM	QD
Total:	3	--
Exceptional:	1	--
On Target:	2	--
At Risk:	--	
Underperforming:	--	--
VHA Best:	--	
Above Nat'l Avg:	--	

Healthy Communities	PM	QD
Total:	0	--
Exceptional:	--	--
On Target:	--	--
At Risk:	--	
Underperforming:	--	--
VHA Best:	--	
Above Nat'l Avg:	--	

Quality	PM	QD
Total:	47	6
Exceptional:	7	2
On Target:	19	3
At Risk:	6	
Underperforming:	15	1
VHA Best:	--	
Above Nat'l Avg:	--	

Satisfaction	PM	QD
Total:	0	--
Exceptional:	--	--
On Target:	--	--
At Risk:	--	
Underperforming:	--	--
VHA Best:	--	
Above Nat'l Avg:	--	

Underperforming

Immunizations - Influenza Outpt - Eleven Clinics
Immunizations - Influenza Outpt - SCI
CAP - Outpt - Influenza Immunization Prior to Admit
AMI - Inpt Reperf Thrombolytic Therapy in 30 min STEMI
AMI - Inpt Reperf PCI in 120 min STEMI
AMI - Inpt Troponin returned within 60 minutes of initial draw
AMI - Inpt ECG in hospital within 10 minutes of arrival
Tobacco - Outpt Counsel 3x/yr - SCI
Tobacco - Outpt Used in the past twelve months - MH

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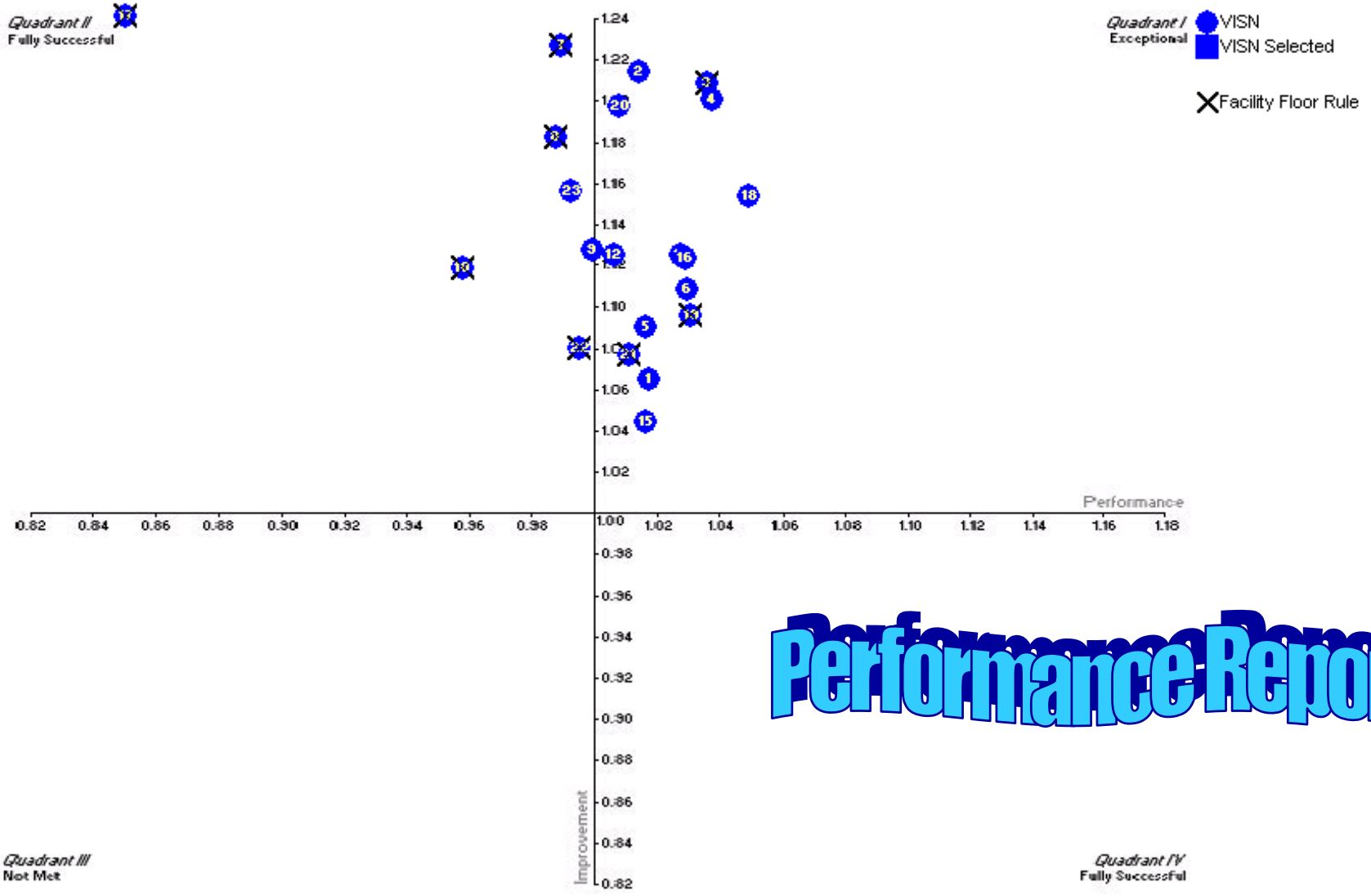
Back Search Favorites Media

Address http://vaww.pdw.med.va.gov/pdwframe.asp

Contact us Period: Q3 2004 VISN:

Q3 2004 : Cardiovascular



Performance Reporting

Edit View Favorites Tools Help

Search Favorites Media

http://vaww.pdw.med.va.gov/pdwframe.asp

Contact us

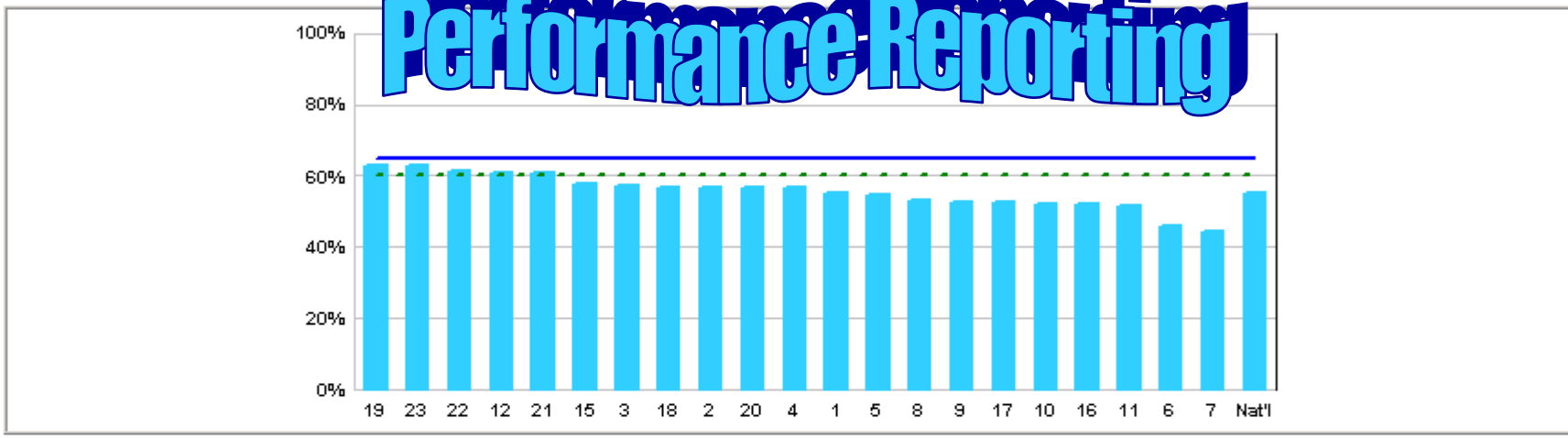
Period: Q3 2004 VISN: National

National Q3 2004 : AMI - Outpt LDL-c < 100 on most recent test AND having full lipid panel in past 2 yr

All VISNs YTD | Graph

ndicator Def.:
ndicator Notes:
tr Numerator:
tr Denominator:
r Numerator:
r Denominator:

Performance Reporting



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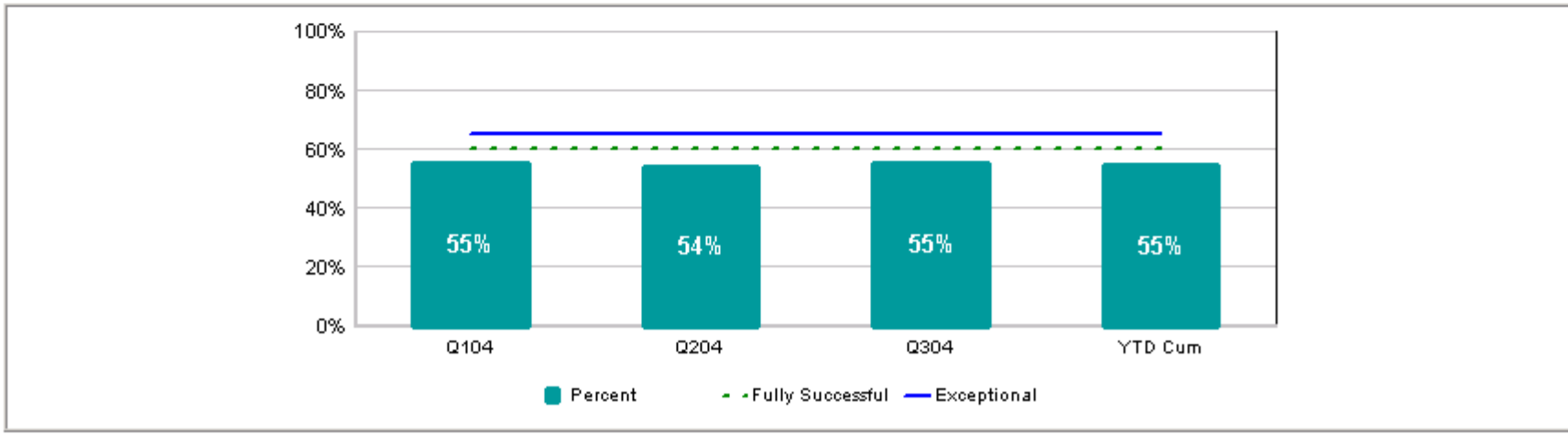
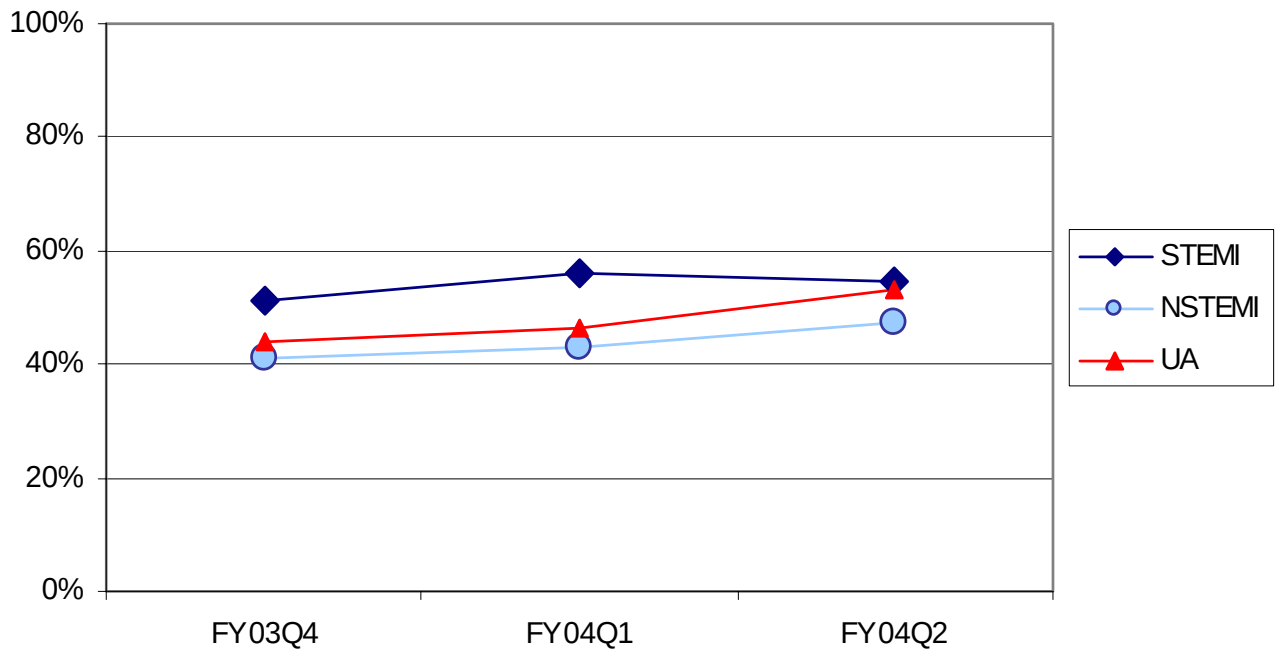


End Of Year Reporting

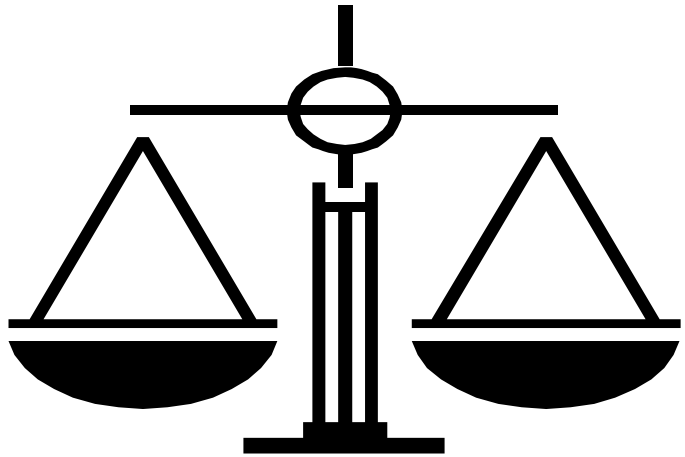
Inpatient ECG in Hospital within 10 Minutes of Arrival



	FY03Q4	FY04Q1	FY04Q2
STEMI	51%	56%	55%
NSTEMI	41%	43%	48%
UA	44%	46%	53%

Public Health Policy and Performance Measurement

Be careful which policy you drive, it just might happen…



Chain of logic that the evidence must support to link the preventive service to improved health outcomes

Primary Prevention ↔ Risk Factor Assessment ↔ Diagnostic Screening ↔ Therapy ↔ Intermediate Outcome(s) ↔ Long Term Outcome(s)

Move VHA toward a system that identifies level of high, moderate, and low cardiovascular risk and thus understands and manages risk across time and at the same level of care regardless of site of entry

Contact

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roxane.rusch@hq.med.va.gov

Cardiovascular Clinical Practice Guideline Metrics

Margaret A. Hawthorne
LTC(P), AN
Quality Management
Chief, Evidence-Based Practice
Fort Sam Houston, Texas 78234

Hypertension

- Percent of eligible patients with an active diagnosis of hypertension whose most recent blood pressure recording was:
  - Less than 140/90
  - Equal to or greater than 160/100 or no BP recorded in the past year

JCAHO ORYX MEASURES AMI

- % of patients given aspirin at arrival of ER
- % of patients prescribed aspirin at discharge
- % of patients with AMI or left ventricular ejection fraction level < 40% be prescribed an ACEI at discharge
- % of AMI patients with a history of smoking within the past year received smoking cessation advice or counseling
- % of patients prescribed a beta-blocker at discharge
- % of patients on a beta-blocker at arrival
- Time to thrombolysis (30 minutes)
- Time to PTCA (90 minutes)
- % Inpatient mortality

Future Core Measures

- Lipid profile drawn within 24 hours of patient arrival for AMI
- % of patients with abnormal lipid profile results with documented plan for lipid management
- AMI mortality within 30 days post AMI

JCAHO
Heart Failure Core Measure Set

- % Heart failure discharge instructions to patient and/or caregiver to include: understand the prognosis of heart failure, the rationale for pharmacotherapy and prescribed medication regimen, dietary restrictions, and activity recommendations, and the signs and symptoms of deteriorating condition
- Number of heart failure patients with documented left ventricular function (LVF) evaluation
- Number of heart failure patients who are prescribed Angiotensin Converting Enzyme Inhibitor(ACEI) for left ventricular systolic dysfunction (LVSD)
- % of HF patients with a history of smoking within the past year received smoking cessation advice or counseling

JCAHO Disease-Specific Care Standardized Heart Failure Measure Set

- Monitor Body Weight
- 90-day return visit to emergency department or admission for heart failure after emergency department discharge for heart failure
- Heart Failure patients with documentation that they or their caregivers received written instruction and/or educational materials addressing all of the following:
  - diet
  - weight monitoring
  - activity level
  - medications
  - symptom management
- Number of patients in which current medication drug dose and frequency is documented in the medical record
- Heart Failure patients with documented left ventricular function (LVF) evaluation
- Heart Failure patients who are prescribed Angiotensin Converting Enzyme Inhibitor(ACEI) for left ventricular systolic dysfunction (LVSD)
- The number of heart failure patients screened for or given influenza vaccination
- The number of heart failure patients screened for or given pneumococcal vaccination
- The percentage of enrolled patients with heart failure with blood pressure <140 systolic, <90 diastolic recorded for the reporting period

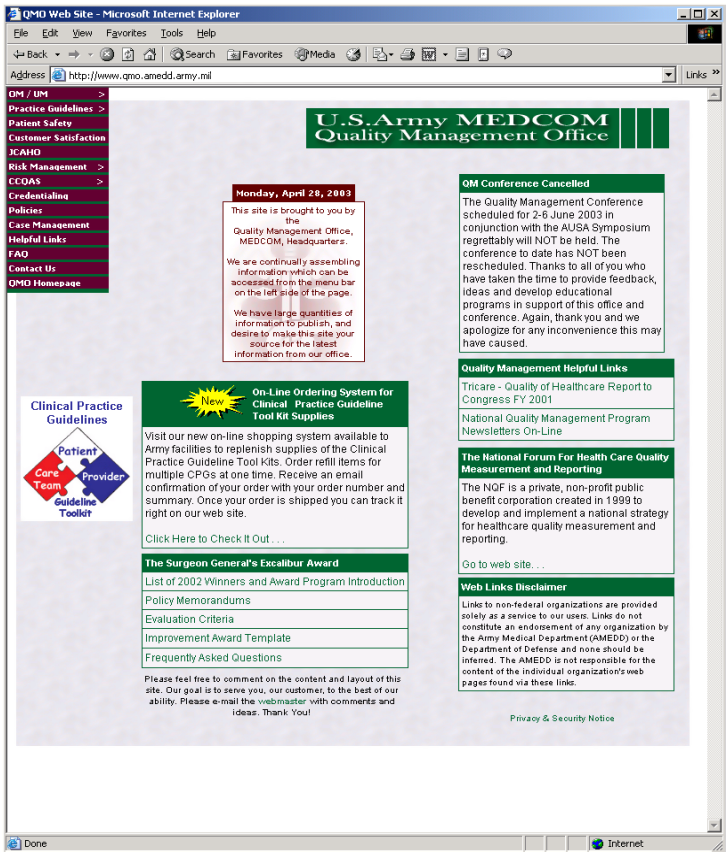
Outpatient CVD Metrics

- % of patients on aspirin at most recent visit or contraindication documented
- % of patients on Beta Blocker at most recent visit or contraindication documented
- % of patients with LVEF <40 on ACEI at most recent visit
- % of patients screened for tobacco use in past twelve months
- % of patients with full lipid profile done within past two years
- % of patients within past 2 years were advised of any lifestyle changes

Web Resources

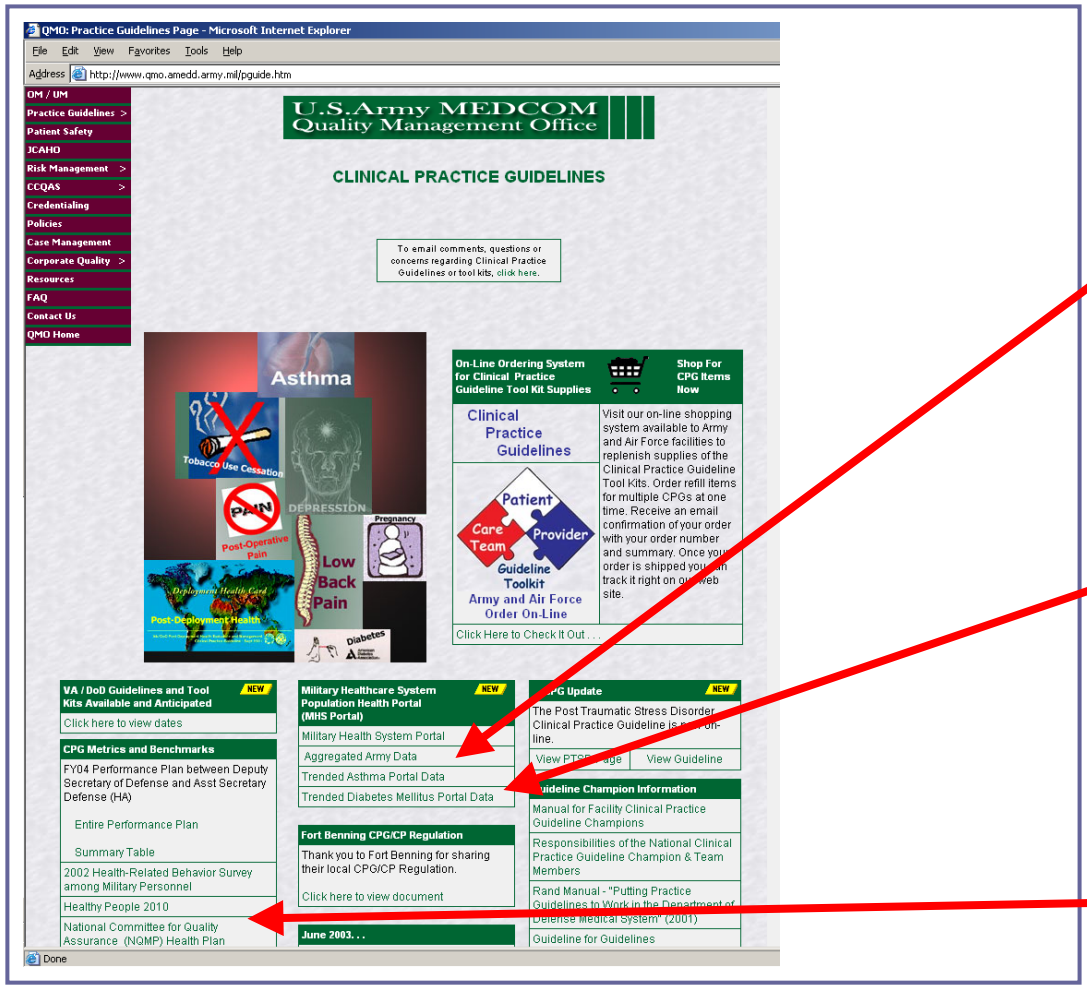
www.QMO.amedd.army.mil *

www.OQP.med.va.gov/cpg/cpg.htm *



*** Where to obtain and reorder CPG Toolkits & materials.**

Aggregate Army Metrics, Trended Diabetes Mellitus Portal, NQMP and HEDIS Data



Aggregated Army Metrics

Trended CVD and DM Portal

NQMP and HEDIS Data

Military Healthcare System Population Health Portal

MHS Population Health Portal

MHSPHP

Improve the Health Status of your Population with the . . .
Air Force Population Health Portal
Naval Population Health Navigator
Army Population Health Information Connection
. . . the one tool for all Services, known as the MHS Portal.

A Tri-Service web-based tool which generates detailed "*Action Lists*" for Clinical Preventive Services, Disease and Condition Management at the Provider and Clinic level for your enrolled beneficiaries:

- Click through "Index Card" design
- Standardized tabular reports with Excel® spreadsheet option
- Detailed methodological guidelines with national benchmarks
- Service level headquarters accounts with aggregate reports available

Demographics Tab:
- Population data stratified by preventive service, age, and gender

Preventive Services Tab:
- Proactively monitor six preventive services through action lists
- Track your success with national HEDIS® benchmarks
- Childhood Immunizations currently limited to Air Force MTFs and one Navy demonstration site

Disease/Condition Management:
- Aggressively manage 10 diseases or conditions with action lists, prevalence reports and aggregate counts
- Track your success with national HEDIS® benchmarks

Request an account *today* at https://pophealth.afms.mil/tsphp

The MHS Portal was developed to meet the Services' request for actionable information for Population Health and Medical Management. Championed by the Population Health and Medical Management (PHMM) Division at TRICARE Management Activity in collaboration with the Population Health Support Division in San Antonio and our Service partners.

PHMM Mission:
Provides policies, instructions, programs, forums, and resources to measure, improve, and sustain the health status of the population.

PHMM Vision:
We are the definitive source for population health information to facilitate the transformation of the MHS from a reactive to proactive healthcare system.

Population Health and Medical Management Division
Office of the Chief Medical Officer, TRICARE Management Activity,
5111 Leesburg Pike, Suite 810, Falls Church, VA 22041
703.681.0064, DSN 761.0064, FAX 703.681.1242

SERVICE RESOURCES

Air Force Population Health Portal	*Naval Population Health Navigator*	*Army Population Health Information Connection*
Lt Col Phillips, USAF, MC	Mrs. Betty Ruschmeier	LTC(P) Margaret A. Hawthorne
AF Population Health Support Division	BUMED-M3M2	MEDCOM-MCHO-Q
210.532.4265 or DSN 240.4265	202.762.3139 or DSN 762.3139	210.221.8297 or DSN 471.8297
chris.phillips@brooks.af.mil		margaret.hawthorne@amedd.army.mil

https://pophealth.afms.mil/tsphp/login/login.cfm